MC0343

Capital Investment Manual

Private Finance Guide

NHS
Executive

This booklet is part of the *Capital Investment Manual*. It outlines key points for consideration with regard to private finance, and should be read in conjunction with the *Business Case Guide*.

The *Capital Investment Manual* comprises the following booklets:

Overview

Project Organisation

Private Finance Guide

Business Case Guide

Management of Construction Projects

Commissioning a Health Care Facility

IM&T Guidance

Post-project Evaluation

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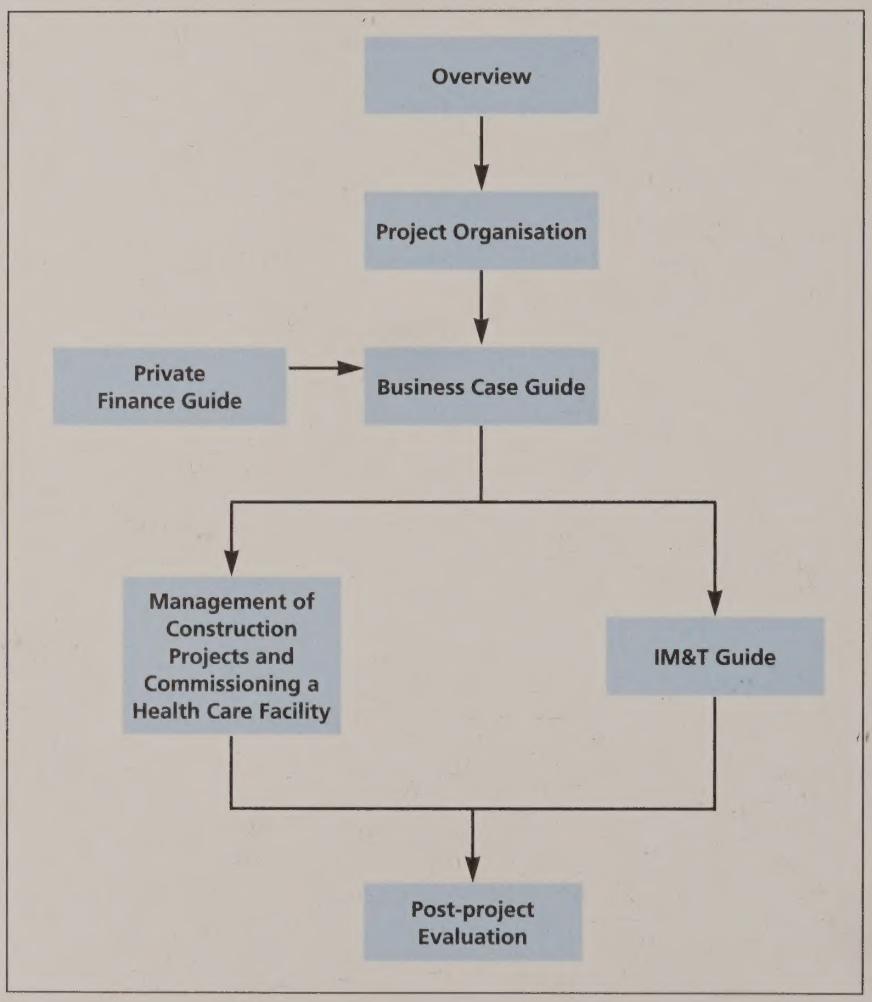

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Introduction

The Private Finance Initiative

'Changes have been made to the rules for privately raised finance. The objective is to find new ways of mobilising the private sector to meet needs which have traditionally only been met by the public sector. The new arrangements are based on risk, which needs genuinely to be borne by the private sector.' (Extract from the printed Autumn Statement, 18 November 1992)

Since the 1992 Autumn Statement there have been a number of changes made to the rules governing the use of private finance. Private finance is being encouraged in the NHS where its use represents good value for money. Private capital can be a way of bringing in private sector skills in controlling costs, managing risks, making use of economies of scale, finding new sources of income, in such a way as to more than compensate for the higher cost of borrowing. Using private finance should be viewed as a standard option whenever a capital scheme is being considered.

To facilitate the closer working of the public and private sectors the NHS Executive has engaged Newchurch and Company to set up and operate a database and enquiry point. It will essentially provide market intelligence, acting as a focal point for bringing the NHS and the private sector together for mutual gain.

The database service:

- gives details of how specific private-sector companies can help the NHS with joint ventures, leasing, or providing capital-intensive services under contract;
- helps private-sector companies find out which Trusts or HAs might be interested in offers to provide particular products or services involving private finance; and
- assists people wanting to pursue similar projects by spreading knowledge of projects that have already been undertaken by NHS Trusts and health authorities, and contains a body of experience and case studies.

If you would like to register with the database, you should ring the advisory line on 071-490 0512.

There are essentially two broad criteria against which all schemes are assessed: 'value for money' and 'assumption of risk'.

Value for money is a test which seeks to establish the option with the highest ratio of benefits to costs. All capital schemes are expected to pass this test, irrespective of their method of finance. The transfer of risk test applies specifically to privately financed projects. It will be assessed on the overall package of risks; the aim is that risks for the NHS should be reduced through the transfer of risk to the private sector.

This guide seeks to explain the key principles underlying the Private Finance Initiative and gives examples of schemes that have been successful. It draws heavily on *Public Service, Private Finance, putting private capital to work for the NHS*, which was issued under EL(93)101. It describes:

- the benefits we are looking for from collaborating with the private sector;
- what joint ventures and market testing can offer;
- when leases and forward sale of land are likely to offer good value for money;
- key factors for the NHS when entering into a contract with the private sector;
- key considerations a good investment appraisal should cover; and
- the approval process for larger schemes.

It also has a list of formal guidance available.

Benefits

Goals

1.1.1 The goals of the Private Finance Initiative are to:

- achieve objectives and deliver services more effectively;
- use public money most efficiently;
- respond positively to private- sector ideas; and
- increase competition, both to spur further improvements in quality and to test value for money, while safeguarding accountability for the use of public funds.

Advantages for the NHS

1.2.1 Involving the private sector can improve the quality of services by:

- getting a wider range of potential providers to compete in terms of quality standards; and
- learning good ideas and better techniques in working with new partners.

1.2.2 Private finance schemes can also increase cost-effectiveness through:

- competition;
- sharing overheads with the private sector and benefiting from economies of scale; and
- taking advantage of the private sector's particular skills and strengths, especially in operating services efficiently.

1.2.3 In addition, risks for the NHS should be lower because:

- risks can be shared with the private sector – this (including the cost) should be spelt out in the contracts agreed – for example, risks over future income or costs, and risks of suboptimal use of assets;
- contracts can give incentives to make sure that things do not go wrong; and
- there can be mutual benefit where the private sector is better placed to minimise and manage risk.

Advantages for Private Sector

1.2.4 Involvement with the NHS offers the private sector both short-term and long-term benefits.

- The private sector will have more scope for doing business with the public sector.
- Firms can exploit their expertise to earn a profit from providing high quality cost-effective services.
- If they win more business, companies can expand and create more jobs.

Joint Ventures

Schemes

2.1.1 Examples of schemes suitable for joint ventures include:

- staff residences, e.g. housing association renovates existing accommodation, or builds new, on NHS site, and sublets to staff;
- new car park, e.g. big enough for both NHS use and private use, offering possible gains from economies of scale and private-sector operation;
- medical waste incineration plant on NHS site;
- combined heat and power plant on NHS site;
- private health care building on NHS site; private partner leases site from NHS; NHS might sell services to the private partner (e.g. radiology) and benefit from income generation;
- NHS places contract with private sector for services requiring capital and management of services to a specification, but continues to provide medical supervision (e.g. satellite renal dialysis);
- NHS and private partner build a patient hotel on a hospital site, for joint use; NHS and private partner share infrastructure costs, with both benefiting from economies of scale; and
- NHS and private partner jointly purchase a major item of medical equipment.

Key Points

2.2.1 *Potential NHS benefits include:*

- reduced costs through spreading overheads and economies of scale;
- acquisition of better techniques from private sector;
- lower risks; and
- income generation.

2.2.2 Permitted schemes include housing association residences for staff on NHS land; developments where NHS and private partner each pay fair share of capital and revenue costs (in proportion to intended use); and schemes in which, after allowing for NHS contribution, private sector recoups its costs by charging private customers.

2.2.3 *Effect on EFL/cash limit:* Not reduced by value of private capital input (but see restriction below).

2.2.4 *Restriction:* The capital is created as bridging loan/lease if NHS puts in less than its fair share of capital by agreeing to pay higher revenue costs later, or if NHS payments are deferred in other ways. If total capital cost is over £250,000 (or £0.6 million – £1 million for larger Trusts) needs prior approval from Regional Office (and from headquarters if sampled).

2.2.5 *Change since 1992 Autumn Statement:* Private sector encouraged to lead joint ventures, let by competition; NHS does not have to compare joint venture with wholly NHS-funded option of same scale (e.g. NHS-only option might be smaller).

Market Testing

3.1.1 Market testing is appropriate for assessing the provision of services to the NHS where the greater part of the cost involves capital expenditure.

Schemes

3.2.1 Examples of schemes suitable for market testing include:

- support services in which there has already been extensive market testing, such as laundry and catering;
- other support services, such as sterile supplies – there may be scope for economies of scale or more efficient (e.g. production line) methods;
- waste disposal;
- facilities for long-stay patients (e.g. new residential schemes) in which accommodation and services for patients are provided under contract to NHS purchasers;
- acute health services, such as dedicated satellite kidney dialysis centres; the contract might be short to meet a temporary need (e.g. to clear a waiting list) or for a period of years, exploiting most cost-effective tenders to provide the service.
- facilities management of information management and technology services; and
- contract for block of work using independent hospital; again, the contract might be short to meet a temporary need (e.g. to clear a waiting list) or for a period of years, exploiting most cost-effective tenders to provide the service.

Key Points

3.3.1 Potential NHS benefits include:

- greater efficiency resulting from competition;
- performance improvements;
- lower risks; and
- freeing up of management to concentrate on core business.

3.3.2 *Allowed:* Where market tested properly.

3.3.3 *Effect on EFL/cash limit:* Not reduced by value of private capital input.

3.3.4 *Restriction:* The use of private capital of more than £250,000 (or £0.6 million – £1 million for larger Trusts) needs prior approval from Regional Office (and from headquarters if sampled). May not contract for lifetime of facility.

3.2.5 *Change since 1992 Autumn Statement:* Provided there is real competition, NHS comparator only required if this would be a realistic alternative on a similar timescale.

Leasing

Examples

4.1.1 Leasing might prove a suitable option in the following cases:

- Crown vehicles;
- contract energy management equipment – often as part of package in which the lessor identifies the best ways of saving energy, and the NHS and lessor share the savings;
- major items of medical equipment, such as scanners – often with a right to terminate early or upgrade to technologically more advanced equipment, when available;
- offices – most likely to meet a short term need; and
- information management and technology services.

Key Points

4.2.1 *Potential NHS benefits include:*

- capacity to meet short-term need;
- greater protection against obsolescence; and
- lower risk to NHS than purchasing especially if difficult to foresee exact duration of requirement.

4.2.2 *Allowed:* Crown vehicles; other cases in which leasing shown to be better value for money than purchasing over the period for which the asset is required (duration of contract).

4.2.3 *Effect on EFL/cash limit:* Not reduced by capital value of asset if great majority of risk retained by private sector. No reduction if lease is an operating lease on SSAP21 definition[1] and capital value is less than £1 million.

4.2.4 *Restriction:* Not allowed if purchase shown to be better value for money than leasing over the period for which the asset is required (duration of contract). If total capital value over £250,000 (or £0.6 million – £1 million for larger Trusts), needs prior approval from Regional Office (and from headquarters if sampled). Prior NHS Executive approval needed for all computers worth over £1 million.

4.2.5 *Change since 1992 Autumn Statement:* Value of asset not counted against EFL if great majority of risk stays with private sector.

[1] Operating leases are defined by the 'Statement of Standard Accounting Practice (SSAP) 21' to be those where substantially all the risks and rewards of ownership of the asset remain with the lessor. The usual financial test of this is whether at the inception of the lease, the present value of minimum lease payments sums to less than 90% of the fair value of the asset.

Forward Sale of Land

5.1.1 Getting the private sector to build a new hospital in exchange for an old site can help the NHS to reduce the risks involved in building it, where the private sector partner might hope to sell the redundant site afterwards. A big risk is that the site might fetch less than had been forecast. Agreeing the sale in advance means the sale price is known beforehand, reducing the risk to the NHS. But the private sector partner will expect a lower price to reflect the risk it is taking on. If the site goes up in value, the NHS obviously loses the benefit of the higher selling price.

Schemes

5.2.1 Situations that entail a forward sale of land could include the following:

- Developer wants site (e.g. for housing) of outdated long-stay NHS institution; developer builds replacement facilities; when these are ready, the old site is vacated and developed; NHS then receives balance of agreed sales proceeds.

- Developer wants part of site (e.g. for supermarket) of NHS town centre hospital that is to be rationalised; developer builds replacement facilities; when these are ready the old site is vacated and developed; NHS then gets balance of sales proceeds.

Key Points

5.3.1 *Potential NHS benefits include:*
- the transfer of risk to private sector, guaranteeing sale income; and
- may help tie in private-sector entrepreneurial skills and management disciplines;

5.3.2 *Allowed:* If efficiency gains offset higher borrowing cost (e.g. the private sector, not the NHS, might bear the risk of inflation in the cost of replacement facilities).

5.3.3 *Effect on EFL/cash limit:* May be reduced by value of loan. (Refer to NHS Executive headquarters.)

5.3.4 *Restriction:* Not allowed if more expensive than Government borrowing and no efficiency gains. Refer to NHS Executive.

5.3.6 *Change since Autumn Statement:* Might be approved if it transfers substantial risks to private sector, and cost of risk transfer worthwhile.

5.3.7 *Note:* Forward sale of land would require Treasury approval in every case – not just if worth more than £10 million. Any such proposal would have to demonstrate better value for money than conventional method, in which NHS pays for new hospital and sells redundant site afterwards. Other ways of managing risk should be fully explored.

Key Factors

Accountability

6.1.1 The contract between the NHS purchaser and the private-sector supplier is critical. It determines the terms on which public money is spent, and it must be defensible as a proper use of public money, ultimately before the Public Accounts Committee. The tests which expenditure will have to satisfy to meet these standards of propriety are broadly threefold.

(a) Value for Money

6.1.2 Firstly, each contract will have to meet a value-for-money test. Any manager responsible for spending public money must be able to show that the expenditure secured a good return for the taxpayer.

(b) Competition

6.1.3 Secondly, and to reinforce a general commitment to value for money, the manager must be able to show that the costs have been appraised against those of alternatives. Competition between alternative providers is, in general, necessary to demonstrate value for money, and can be a spur to quality. In many cases it is a requirement of EC procurement rules. However, there may be wider issues for consideration, including the ownership of intellectual property, the terms upon which providers are asked to compete and the encouragement of innovation.

6.1.4 Cosy relationships, where the performance of a private contractor is not tested regularly and rigorously in an open market place, must not be allowed to develop.

(c) Independence

6.1.5 Finally, a contract with a private-sector supplier must preserve the independence of both parties – the public-sector purchaser must preserve a reasonable degree of freedom to take business elsewhere; the private-sector provider must retain the commercial risk that attaches to the venture. It is not the function of a public-sector purchase contract to guarantee a return to a private-sector service provider – that is not an aim of the Private Finance Initiative.

Added Value

6.2.1 These three tests serve to emphasise that what is sought is not merely the provision of private-sector finance – the public-sector has always had access to that through the gilts market. Rather the added value comes from private-sector disciplines and management. The manager of a project must assess its viability by looking at the capacity of revenues to cover costs and produce a return to its investors. That is the discipline which is lacking in public-sector provision, and which will, when linked with open competition among suppliers, provide the spur to improvement in the quality of public services.

Investment Appraisal

7.1.1 The *Business Case Guide* gives full details on the preparation of a business case. The decision to use private finance does not negate the need for a properly structured business case. However, it is worth outlining the key requirements of a business case for an investment that involves the use of private finance.

Discounting

7.2.1 Private finance proposals must pass both a 'value for money' and a 'transfer of risk' test. In order to do this, the annual total cost figures for each option need to be discounted. The appropriate discount rate to use is 6% with all costs at constant prices. However, if a lease option is involved then costs should be at nominal prices and the discount to use is the National Loans Fund (NLF) interest rate + 2%. SSAP21, the relevant accounting standard, recommends using a discount rate based on the interest rate implicit in the lease, i.e. the interest rate at which the lessor is borrowing funds. However, this 'implicit rate' is often not known by the lessee, in which case the NLF rate + 2% should be used. In any case it is only appropriate to use the implicit rate to test the transfer of risk for assets below £1 million. Value for money calculations for leases should always be based on the NLF rate + 2%. Worked examples showing how these two tests can be applied are given opposite.

TRANSFER OF RISK

7.3.1 Taking a lease of an asset with a capital value of £1 million as an example, the appropriate test is the '90% test'[1], i.e. the present value of the minimum lease payments must sum to less than 90% of the fair value of the asset. In this example, the lease rental payments are £150,000 per year. The lease period is assumed to be seven years.

7.3.2. To perform the 90% test, the annual rentals are discounted. The discount factors in the first part are based on the National Loans Fund (NLF) interest rate + 2%. With an NLF interest rate of 6.5%, the discount rate would be 8.5%. The discounted rentals are shown in the fourth column. When these are summed over the seven years, they come to £833,038. As this is only 83.3% of the capital value, it passes the 90% test.

7.3.3 In other words, the lessee is only committed to paying for about 83% of the value of the asset. The remaining 17% of the value has to be recovered by the lessor through some other means – probably through selling the asset second-hand at the end of the lease – but this is at the lessor's risk.

[1] For assets with a value over £1 million the appropriate risk transfer test is that the minimum of lease rental payments be no more than 70% of the fair asset value. The discount rate to use in such cases is always the NLF rate + 2%.

VALUE FOR MONEY

7.4.1 Staying with the same example, the value for money test is based on a comparison with the purchase option. The purchase cost is £1 million. After the seven years of use, the owner is able to sell the asset, and in this example it is assumed to have a sale value of £250,000. After discounting, the present value of this sale price is only £141,232. Hence the net cost of purchase is £858,768. As the net discounted cost of the lease is only £833,038, purchase is more expensive.

Criteria used to Judge Private Finance Business Cases

Good Business Cases

7.5.1 In a good case, value for money will have been properly checked. At a minimum, this involves:

- appraising a broad range of options, including the status quo;
- explaining the benefits, and how these differ between options;
- explaining how cost forecasts have been derived, and how costs differ between options;
- explaining where risks lie, contractual obligations, differences between options, and how involving the private sector reduces risks for the NHS; and
- correct calculation of net present values for shortlisted options.

7.5.2 The case will show convincingly that the option proposed offers the NHS the best value for money because it:

- has greater benefits/lower risks, at no more cost;
- is cheaper, without sacrificing benefits or incurring greater risks;
- has greater benefits/lower risks at justified extra costs..

Bad Business Cases

7.6.1 In a bad case, value for money will not have been properly checked. These are business cases

with any of the following major flaws:

- inadequate range of options (only two or less);
- no analysis of benefits;
- no explanation of costs;
- no analysis of risks; or
- for shortlisted options, net present values missing, or miscalculated.

There may even be cases in which the option that is proposed offers worse value for money, for example, it is more expensive without any other gains; or has poorer benefits or greater risks, without commensurate cost savings.

TABLE 1: MODEL OF THE 90% AND VALUE FOR MONEY TESTS

NLF rate: 6.5%

NLF rate + 2%: 8.5%

Capital value: £1,000,000

Year	NLF + 2% Discount factor	Rental £000	Discounted rental (NPC)	Purchase cost £000	Discounted purchase
1994	1.000	150	150.000	1000	1000
1995	0.922	150	138.249		
1996	0.849	150	127.418		
1997	0.783	150	117.436		
1998	0.722	150	108.236		
1999	0.665	150	99.757		
2000	0.613	150	91.942	(250)	(141.232)
Totals		1050	833.038	750	858.768

Results:

(1) The sum of discounted rentals (the net present cost) is 833.038, which as a percentage of the capital value is 83.30%.

Therefore this lease passes the 90% transfer of risk test.

(2) The discounted net cost of purchase is 858.768, which is higher than the net discounted cost of the lease, 833.038.

Therefore, this lease is better value for money than purchase.

Contracts: Key Points

Requirements for Contracts

8.1.1 The following are important points to watch out for.

- Both provider and purchaser know what the specification requires.
- The contract should contain a description of the procedure for managing the contract, including agreed measurable performance targets which will be monitored.
- The contract should include an agreed procedure to cover complaints on either side.
- Where appropriate, both parties to the contract should seek independent financial advice.
- Any financial risk should be spread amongst the commercial partners.
- Both the provider and the purchaser should have a good audit trail through all the systems that are to be used.
- The contract should require, as far as possible, an 'open book' policy for audit purposes.

Good Practice in Contracting

8.2.1 Good practice in contracting is essential for success.

- Start consultation with possible providers of the service as soon as it is decided to contract the service.
- Treat all possible tenderers equally.
- Wherever possible use actual (not budget) operating costs to compare in-house with outside contractors.
- Always evaluate tenders using experts in the particular discipline.
- Ensure the experts provide written reports on their evaluation and use these to debrief unsuccessful tenderers at a later stage.
- Wherever quality and value for money are to be tested, follow the general principles of the HMSO publication *Market Testing in the NHS* (issued with EL(93)55). (For example, the period of contract can now be up to seven years at the discretion of the Trust chief executive, and longer contracts may be appropriate in some circumstances.)

Developing Contracting with the Private Sector

8.3.1 The Purchasing Unit of the NHS Executive's Performance Management Directorate is taking forward work with the private sector on contracting, with the aim of issuing further good practice guidance to the NHS, including model contracts on purchasing and patient care, later this year.

Approval Requirements

Delegations

9.1.1 For schemes under £1 million, proposals are dealt with in just the same way as ordinary capital schemes by Trusts. This means that

- medium-sized Trusts (whose income is between £30 million and £80 million) can approve their own schemes up to £600,000 capital value;
- larger Trusts can approve their own schemes up to £1 million capital value; and
- smaller Trusts can approve their own schemes up to £250,000 capital value.

9.1.2 Above those limits, the NHS Executive Regional Office must be satisfied with the case.

9.1.3 Between £1 million and £10 million, private finance schemes are sampled at random (and the sampling decision is made immediately). For schemes not sampled, the Regional Office can approve the business case. For those that are, the NHS Executive Headquarters needs to give approval. If a sampled scheme is over £4 million, the proposal also goes to the Treasury.

Big Schemes

9.2.1 All schemes over £10 million need NHS Executive Headquarters and Treasury approval.

9.2.2 Schemes that are classed as 'novel or contentious' will also need Treasury approval. If in doubt, please consult the NHS Executive.

Approval Process

9.3.1 When the NHS Executive Regional Office is satisfied with it, the business case should be sent to FCID for possible sampling.

Further Guidance

Guidance from the NHS Executive

10.1.1 FDL(93)03 gave general guidance about the private finance initiative and stressed that the key was significant transfer of risk to the private sector. This FDL included the Treasury general guidance about the Private Finance Initiative of December 1992.

10.1.2 FDL(93)33 explained the approval requirements and delegated limits. It included the DoE guidance on Contract Energy Management and the Treasury guidance on Joint Ventures.

10.1.3 FDL(93)47 gave further guidance on leasing and included a Treasury paper on leasing. It explained that when the great majority of the risk lies with the private sector, the capital value of leased assets is not scored against expenditure provision.

10.1.4 FDL(93)61 gave guidance for financial institutions and others trading with NHS Trusts.

10.1.5 FDL(93)71 circulated a Treasury consultation paper on competition and related issues, such as the ownership of intellectual property and encouragement of innovation.

10.1.6 EL(93)55 gave revised guidance on market testing. The guidance manual with this EL contains many points that should be considered before private finance contracts are placed.

10.1.7 HSG(93)8 gave guidance on notifying tertiary extra-contractual referrals. It asked purchasers to review contracting arrangements to assess services which may appropriately be purchased from the private or independent sector and to include these within the range of contracts available to consultants and general practitioners.

Other Guidance

10.2.1 Guidance documents on Contract Energy Management from the Department of the Environment's Energy Efficiency Office, and from the Treasury on the Private Finance Initiative, Joint Ventures, Leasing, and Competition, were attached to the above FDLs.

10.2.2 The Treasury booklet, *Breaking New Ground* gives an accessible account of the aims and scope of the Private Finance Initiative, and includes examples of joint ventures between the public and private sectors.

10.2.3 *The Economic Appraisal of Property Options: a Manual of Procedures and Techniques* published by the Treasury provides a full explanation of the principles to be followed when conducting an option appraisal involving property. Copies are available from the PSE division of HM Treasury.

Appendix 1: Satellite Kidney Dialysis Centre

What is it?
The Satellite Kidney Dialysis Centre is a service provided under contract to the Sheffield Northern General Hospital NHS Trust.

What does the scheme entail?
The service provides kidney dialysis to patients referred from the Northern General, at a satellite site in Rotherham (in the grounds of the Rotherham District General Hospital). It is run by Community Dialysis Services (Priory Hospitals Group), which has experience of other similar schemes. The patients remain under the care of the nephrology consultants at the Northern General.

How does it benefit NHS patients?
It reduces travel. Patients who are suitable for maintenance dialysis and who live locally can be dialysed nearer home, rather than having to travel to Sheffield, which could involve a long wait for an ambulance trip.

Does it improve quality?
Industry standards were agreed with the Northern General and are rigorously enforced. Treatment uses the latest dialysis machines. The unit is more homely and provides high-quality individual care.

What other advantages does it have?

- Simplicity: the Northern General pays a fixed charge per patient referred, plus an annual standing charge.
- Speed: construction and commissioning of the unit took eight months.
- Resources: CDS had full responsibility for designing, equipping, staffing and commissioning, and has continuing management responsibility, releasing Northern General staff time.
- Integration: where possible CDS contracts with NHS support services for catering, housekeeping, maintenance, portering and certain laboratory services, returning money to the NHS.

How is quality monitored?
Tests are carried out regularly to check that patients are being correctly dialysed. Blood samples are tested by the Northern General's own labs. Patients are regularly surveyed for their views. Units are regularly inspected by the NHS inspection teams, as required by the Registration of Nursing Homes Act 1984.

Why is it more cost-effective?
The service is provided from a dedicated, purpose-built special unit. The unit is run by nurses. The company operates the service very efficiently.

How does it reduce risks for the NHS?
The NHS gains greater flexibility to vary the number of patients treated in the satellite locality. This is useful, as the demand for dialysis in the future is uncertain. The contract is for seven years.

What persuaded the NHS Executive to approve the scheme?
It gained approval because the business case showed that using the private sector was more cost-effective than in-house provision, the contract was for less than the life of the unit, and because risks for the NHS were reduced.

What was the effect on capital budgets?
Northern General avoided the need to build and equip the unit, and the capital value was not counted against its external financing limit.

How was private sector involvement sought?
Northern General invited companies to tender to provide the service.

Who was involved locally?
The Northern General's Director of Finance, a consultant nephrologist, a senior nurse, the Business Manager of the Sheffield Kidney Institute as well as the Assistant General Manager, the Director of Estates and other senior nursing and management staff of the Rotherham District General NHS Trust.

What has happened so far?
The contract was awarded to CDS in April 1992. The unit opened in November 1992 and 25 patients have transferred to the Unit; others attend for occasional treatments.

Where can I find out more?
In the first instance, contact the Business Manager at the Sheffield Kidney Institute (0742-434343 ext. 4738). Alternatively, for the Priory Hospitals Group's view, contact their Community Dialysis Services Operations Manager, Mr Lee Reed (081-878 9559).

Appendix 2: Lease of a Scanner

What does this scheme entail?
This scheme entails the Newcastle Royal Victoria Infirmary (RVI) NHS Trust leasing a magnetic resonance imaging (MRI) scanner for use at the RVI.

How does it benefit NHS patients?
The small number of existing MRI scanners is heavily oversubscribed, with long waiting lists. Patients will no longer have to travel to other locations for diagnosis. MRI can replace more invasive treatment methods.

Does it improve quality?
The scanner will be operated by NHS staff in the same way as if it had been bought – but in future years, if technology changes, the RVI can easily upgrade to more advanced technology.

How will quality be monitored?
Initial quality assurance testing will be performed on behalf of the Evaluations Group of the Medical Devices Directorate. There tests will be used as a baseline for subsequent in-house testing.

What other advantages does it have?
The RVI's annual payments are fixed in advance and include equipment lease, service costs and salaries. This greatly facilitates financial planning.

Is it more cost-effective?
The business case showed that the present value of lease payments would be less than the purchase cost, over the life of the machine.

How does it reduce risks for the NHS?
The NHS gains protection against the risk of obsolescence.

What persuaded the NHS Executive to approve the scheme?
The NHS Executive granted approval because the business case showed that leasing was more cost-effective than purchasing, and because risks for the NHS were reduced.

What was the effect on capital budgets?
The capital value was not counted against the RVI's EFL.

How was private sector involvement sought?
The RVI appraised the choice between all the available scanners and considered alternative financing options.

Who was involved locally?
The RVI Director of Finance, the Clinical Director of Radiology, a consultant radiologist, and a superintendent radiographer.

What has happened so far?
The order has now been completed. The scanner commenced operations in mid-September 1993.

Where can I find out more?
In the first instance, contact the Executive Director of Finance and Information Services at the RVI (091-232 5131).

Appendix 3: Clinical Waste Incineration

What will the scheme entail?
A private company will build and operate a waste incineration plant on the site of the William Harvey Hospital, Ashford, Kent. The incinerator will be used by a wider consortium of NHS hospitals in Kent. It will have some spare capacity, which the private company is responsible for selling.

How will it benefit the NHS?
The cost per tonne of waste will be less than other NHS-only options.

Will it improve quality?
It will help the NHS meet new emissions standards.

How will quality be monitored?
The joint venture company will operate to British Standard 5750. Clients will be able to view the operation and ensure that a duty of care is being exercised. Enforcing authorities will have a monitoring role.

What other advantages will it have?
The NHS will gain access to specialised expertise in disposing of waste in compliance with environmental protection legislation.

Why will it be more cost-effective?
By joining together as a consortium and by adding the private-sector capacity, all members will gain the advantage of economies of scale.

How will it reduce risks for the NHS?
It is proposed that the host hospital's waste incinceration contract to provide clinical waste to the plant will be for ten years only. Other consortium trusts and authorities will have a five-year commitment. There will be no pre-set minimum quantity of waste that the consortium members must send. If legislative requirements are raised, the private company will be responsible for improving the performance of the plant.

What persuaded the NHS Executive to approve the scheme?
It gained approval because the business case showed that using the private sector would be more cost-effective than in-house provision, the contract was for less than the life of the unit, and because risks for the NHS would be reduced.

What was the effect on capital budgets?
The RHA and consortium members avoided the need to build and equip the plant, and the capital cost was not counted against their capital allocations or EFLs.

How was private sector involvement sought?
Consultants advised on possible partners; many potential tenderers were considered.

Who was involved locally?
The project was coordinated by a task group at South East Thames RHA. The local Director of Estates is managing the venture.

What has happened so far?
Since approval, site planning has continued. The scheme is to be in operation by October 1995.

Where can I find out more?
Contact the Director of Estates, South East Thames RHA (0424-730073, ext 2229).

Appendix 4: Long-stay Residential Care

What will the scheme entail?
The Metropolitan Housing Trust, a housing association, will provide, under contract for Barnet Health Authority, a 24-bed nursing home for elderly people with mental health problems, and a 16-place hostel for younger people with mental health problems, in a setting of social housing. The housing association is in partnership with Servite, a voluntary organisation specialising in the care of people with mental health problems.

How will it benefit NHS patients?
The patients will live in small, modern units, which will be located in their home community, rather than in a large, Victorian institution, which is gradually being run down, situated outside the District.

Will it improve quality?
This service will promote care in the community.

What other advantages will it have?
Servite have considerable experience of running small units of the type to be built.

How will quality be monitored?
Premises operated by Servite are inspected and registered by DHA officers, and a management agreement will specify standards of care.

Why will it be more cost-effective?
The units have been designed by MHT/Servite to accord with their own management procedures, ensuring a very effective and efficient delivery of this service.

How will it reduce risks for the NHS?
Barnet DHA initially has a ten-year contract for this service. It has the option to extend its nomination rights in full or in part for a further 10 years, or to cease using this service.

What persuaded the NHS Executive to approve it?
It gained approval because the business case showed that using the private sector was more cost-effective than in-house provision, the contract was for less than the life of the units, and because risks for the NHS were reduced.

Effect on capital budgets?
The DHA avoided the need to build and equip the units, and the capital cost was not counted against its capital allocation.

How was private sector involvement sought?
A competition was held between private healthcare providers and voluntary organisations inviting innovative proposals, for a unit offering a minimum of 30 places for people with mental health problems.

Who was involved locally?
A working group at the DHA specified the requirements, and the property managers at the RHA provided assistance with developing the project.

What has happened so far?
Contracts are about to be signed. The scheme is planned to be in operation by 1995.

Where can I find out more?
In the first instance, contact the Assistant Property Manager, North West Thames RHA (071-725 5331).

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